

8507

## CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Huntingtown</u>		<u>Life</u>		OR TOWN <u>Huntingtown</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Nathie' P. Bucklew</u>				<u>Sept. 3, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>W</u>	<u>Oct. 19, 1866</u>	<u>88</u> yrs.	<u>10</u> Months <u>14</u> Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Calvert Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James W. Gibson</u>				<u>Ann Boyd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>If no</u>		<u>No</u>		<u>Calvert C. Bucklew - Huntingtown, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerotic C.V. disease</u>							
ANTECEDENT CAUSE (B): DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>July 25, 1953</u> , to <u>10/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 25, 1955</u> , and that death occurred at <u>10/1</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		ADDRESS <u>[Signature]</u>		DATE SIGNED <u>9/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 6, 1955</u>		<u>Calvary Cemetery</u>		<u>Huntingtown - Calvert Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9-6-55</u>		<u>H.W. Ward</u>		<u>A. A. Haskness &amp; Son - Mutual, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8558

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

Reg. Dist.

08517

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	
<u>X</u> TOWN <u>Solomons</u>	<u>6 yrs.</u>	TOWN <u>Solomons</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Raymond, Sgt Elkins</u>		STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<u>Hoag</u> (First) <u>Elkins</u> (Last)		<u>9</u> (Month) <u>4</u> (Day) 19 <u>53</u> (Year)	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>7/4/187</u>
9. AGE last birthday: <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Texas (Pike)</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William Barton Elkins</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No.: <u>578-14-1708</u>	
17. INFORMANT & ADDRESS: <u>Diol H. Elkins</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1</u> <u>Coronary thrombosis</u>			
DUE TO			
Antecedent cause(s) (b) <u>Found dead in bed</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) (County) <u>Calvert</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8/9/15</u>	
		DEPUTY MEDICAL EXAMINER	
		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Interred</u>	DATE THEREOF <u>Aug 15, 1953</u>	NAME OF CEMETERY OR CREMATORY <u>Celeste Cemetery</u>	LOCATION (City, town, or county) (State) <u>Celeste, Texas</u>
DATE RECD BY LOCAL REG. <u>9-2-53</u>	REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	24. FUNERAL DIRECTOR <u>G. A. Harkness &amp; Son - Mutual, Md</u>	

BUREAU V. S.

SEP 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

85-9 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08518				CERTIFICATE OF DEATH		Reg. Dist. No. 51	
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cabret</u>		MARYLAND		STATE <u>Ind</u> COUNTY <u>Cabret</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>St. Leonard</u>		<u>4 days</u>		TOWN <u>Lucy</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
08				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Sarah M. Hagelin</u>				DATE: <u>Sept. 4, 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>M</u>		8. DATE OF BIRTH: <u>May 8, 1885</u>	
9. AGE last birthday: <u>70</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>			
13. FATHER'S NAME: <u>Samuel McClain</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah E. Burton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT & ADDRESS: <u>George H. Hagelin, St. Lucy, Ind</u>							
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>442X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Hypertensive cardio vascular</u>							
DUE TO <u>renal disease.</u>							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/9/55</u> , 1955, to <u>9/4</u> , 1955, that I last saw the deceased alive on <u>9/4</u> , 1955, and that death occurred at <u>930 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>M. D. Huntingtontown</u>			
DATE SIGNED <u>9/5/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 7, 1955</u>		<u>Middleham Chapel Co.</u>		<u>Lucy - Cabret Co - Ind</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9-6-55</u>		<u>H. W. Ward</u>		<u>A. G. Harkness</u>		<u>Lucy - Huntingtontown - Ind</u>	



RECEIVED

SEP 7 1955

BUREAU V. A.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08519

8510

Item 12, Film 186 9-21-55 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Lusby</u> )		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lusby</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Serge G. Koushnareff</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Serge G. Koushnareff</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>10</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH: <u>Dec 21, 1943</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>US Journal</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	
13. FATHER'S NAME: <u>Ses Koushnareff</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie Ely Popoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS: <u>Mrs Bessie Koushnareff</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (B) <u>(A) Coronary Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C) <u>Impaled dead in garage</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (City or town) <u>Lusby</u> (County) <u>Calvert</u> (State) <u>md</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u>							
SIGNATURE <u>H W Ward</u>		ADDRESS <u>Phila D. Gray</u>		DATE SIGNED <u>9/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Middleham Chapel</u>		LOCATION (City, town, or county) (State) <u>Lusby, Calvert Co., Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/12/55</u>		REGISTRAR'S SIGNATURE <u>A. H. Ward</u>		24. FUNERAL DIRECTOR <u>G. D. Harkness</u>		ADDRESS <u>1500 N. Central, Md.</u>	

BUREAU V. 4

ED 15 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08520

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Prince Frederick</u>		<u>3d. 9 hrs. - 20 min.</u>		DR TOWN <u>Prince Frederick</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Gerald Anthony Mackall</u>				<u>Sept. 4 1955</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Feb. 7, 1915</u>	9. AGE last birthday: <u>40</u> yrs.	IF UNDER 1 YEAR: <u>6</u> Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Calvert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Clarence Mackall</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
9							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A) <u>Brucellosis</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>9/1</u> <u>1955</u> , to <u>9/4</u> <u>1955</u> , that I last saw the deceased alive on <u>9/4</u> <u>1955</u> , and that death occurred at <u>8:30</u> <u>P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. Huntington</u>		DATE SIGNED <u>9/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>9-6-55</u>		<u>Porter</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-6-55</u>		REGISTRAR'S SIGNATURE <u>N. W. Ward</u>		24. FUNERAL DIRECTOR <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick Md.</u>	

BUREAU V. S.

SEP 7 1965

RECEIVED

08521

STATE DEPARTMENT OF HEALTH

MARYLAND

8512

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH- COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Prince Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> X	
TOWN <u>Prince Frederick</u>		TOWN <u>Prince Frederick</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cornell Hospital</u>		STREET ADDRESS (If rural, give location) <u>Prince Frederick, Md</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>F</u> (Last) <u>Myers</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9-16-1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 2, 1899</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Samuel Myers</u>		14. MOTHER'S MAIDEN NAME <u>Annie Root</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-12-5254</u>	
17. INFORMANT AND ADDRESS <u>Martha Myers, Lurby, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		III. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a)..... <u>Heart failure</u>					
Antecedent cause(s) (b)..... <u>Coronary occlusion - Enlarged heart</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>11</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 10</u> , 19 <u>55</u> , to <u>Sept 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>55</u> , and that death occurred at <u>9:50 p.m.</u> , from the causes and on the date stated above.		SIGNATURE <u>J. Williams</u> (Degree or title)		ADDRESS <u>St Thomas</u> DATE SIGNED <u>9/20</u>	
23. BURIAL CREMATION REMOVAL (Specify)		DATE <u>9-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>St John</u> LOCATION (City, town, or county) <u>Calvert</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>9-19-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		24. FUNERAL DIRECTOR <u>P. E. Sewell</u> ADDRESS <u>Prince Frederick, Md</u>	

MARGIN RESERVE FOR BINDING

100

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8513

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09591

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Prince Frederick</u>		LENGTH OF STAY (in this place) <u>39 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barstow</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Augustus Putnam</u>				OF DEATH: <u>9 - 30 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>January 25, 1866</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>John Putnam</u>				14. MOTHER'S MAIDEN NAME: <u>Viola Commins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>MRS. Verna Bailey - Barstow, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE		(A) <u>Carcinoma of prostate</u>					
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)					
		DUE TO					
		(C)					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/21, 1955</u> , to <u>9/30, 1955</u> , that I last saw the deceased <u>alive on 9/20, 1955</u> , and that death occurred at <u>4:15 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Weinstock</u>		ADDRESS <u>M. D. Huntington</u>		DATE SIGNED <u>9/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Columbians Garden</u>		LOCATION (City, town, or county) (State) <u>Arlington, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-30-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		24. FUNERAL DIRECTOR <u>C. F. Pres</u>		ADDRESS <u>Arlington, Md.</u>	



RECEIVED

OCT 10 1955

BUREAU V. S.

8514

08522  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>H. Pearl</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Mt Rainier</u>	<u>161-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <u>Robert</u> (Middle) <u>1</u> (Last) <u>Wood</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>9/3/1901</u>
9. AGE last birthday: <u>54</u> yrs.		10. IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Store</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Store</u>	
11. BIRTHPLACE (State or foreign country): <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>	
13. FATHER'S NAME: <u>Robert Wood</u>		14. MOTHER'S MAIDEN NAME: <u>Ann Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>42051</u>	
17. INFORMANT & ADDRESS: <u>Mr. Edith Wood, Mt Rainier</u>			

18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Drown</u> Antecedent cause(s) (b) <u>giving rise to the above cause stating underlying cause last</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Was swimming in the Bay</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, Of street, office bldg., etc.) INJURY <u>Bay</u>	21c. (City or town) (County) (State) <u>H. Pearl Calvert MD</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>A. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/5/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>9/8/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Fort Lincoln</u>
LOCATION (City, town, or county) (State): <u>Prince George's Md</u>	24. FUNERAL DIRECTOR	ADDRESS: <u>Wm H. Hulsebus, Pwings, Md</u>
DATE REC'D BY LOCAL REG: <u>Sept. 5 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Hulsebus</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 9 1955

BUREAU V. B.